Genetic and Molecular Diagnostic Testing Authorization Request

Please fax the completed form:

- For Tufts Health Plan Commercial, Tufts Health Freedom Plan: 617.972.9409
- For Tufts Health Public Plans: 888.415.9055
- Tufts Health RITogether — A Rhode Island Medicaid Plan; Fax: 857.304.6404
- Tufts Health Freedom Plan products: Fax: 617.972.9409

DATE OF REQUEST: _____

REQUIRED DOCUMENTATION

Submit the following required documentation:

- Completed Genetic and Molecular Diagnostic Testing Authorization Request Form
- Letter of medical necessity from genetic counselor, including pedigree analysis and genetic counselor's recommendation for testing
- Letter of medical necessity which indicates how the test results will be utilized in the medical management of the Member to significantly improve patient/treatment outcome, including diagnostic or therapeutic interventions necessary to address risks to the member's health caused by the suspected genetic disorder Note: Testing solely for the purpose of informing the care or management of Member's family member(s) will not be covered.

Note: Failure to complete form entirely and submit required documentation may result in delay of processing

MEMBER INFORMATION

Member Name: _____ Member DOB: _____

Member ID#: _____ Gender: _____

PROVIDER/LABORATORY INFORMATION

Provider/Laboratory Name: _____ Provider/Laboratory NPI #: _____

Provider/Laboratory Phone #: _____ Provider/Laboratory Fax #: _____

NOTE: Blood or specimens should not be collected until after the genetics counselor has made a recommendation regarding the test *and the request for prior authorization has been approved*. Testing must be performed at a contracted lab when available.

REFERRING PHYSICIAN INFORMATION

Referring Physician Name: _____ Referring Physician NPI #: _____

Referring Physician Phone #: _____ Referring Physician Fax #: _____

Is referring physician

- An MD geneticist? ☐Yes ☐ No
- An MD with expertise in treating the targeted disease? ☐ Yes ☐ No

Date required genetic counseling completed: _____

- Is genetic counselor a board certified genetic counselor or MD geneticist? Yes ☐ No ☐

REQUESTED TESTING

Specific test being requested (include analytic gene, type of analysis):

_____

Test: _____ CPT/HCPCS code: _____

Test: _____ CPT /HCPCS code: _____

Test: _____ CPT /HCPCS code: _____

Diagnosis (ICD-10) to support request for genetic test:

_____

REASON FOR GENETIC TEST

☐ Screening testing
☒ Diagnosis testing
☐ Predictive/prognostic testing
☐ Drug response testing
☐ Monitoring testing
☐ Carrier testing
☐ Prenatal testing

Has less intensive testing been completed? ☐ Yes ☐ No If yes, list previous testing:

Test	Date of Testing	Mutation Identified?	Specific Mutation Identified
_____	_____	☐ Yes ☐ No	_____
_____	_____	☐ Yes ☐ No	_____

PERSONAL AND FAMILY HISTORY

Personal history of this diagnosis? ☐ Yes ☐ No If yes, list history of related diagnoses/disorders:

Diagnosis	Age at Time of Diagnosis
_____	_____
_____	_____

Family history of this diagnosis or related disorders:

Relationship	Maternal/ Paternal	Diagnosis	Age at Time of Diagnosis	Family Member Deceased?	Was Genetic Testing Completed?	Family Mutation (if known)?
_____	☐ M ☐ P	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
_____	☐ M ☐ P	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PRENATAL/CARRIER

Does spouse/reproductive partner have a history of known family mutation, disorder or related disorder?
☐ Yes ☐ No
If yes, explain:
_____
_____

Does a previous child have a history of known disorder, related disorder of family mutation? ☐ Yes ☐ No
If yes, explain:
_____
_____

FOR BRCA TESTING ONLY

Member's ethnic background (e.g., Ashkenazi, Western Northern Europe, Asia):
_____